DOCUMENT RESUME

ED 125 385 HE 007 831

AUTHOR White, Donald K., Ed.
TITLE Education for Health Services Administration in the United Kingdom. Program Notes, Number 66.
INSTITUTION Association of Univ. Programs in Health Administration, Washington, D.C.
PUB DATE Dec 75
NOTE 56p.
AVAILABLE FROM Association of University Programs in Health Administration, Suite 420, One Dupont Circle, Washington, D.C. 20036

EDRS PRICE MF-$0.83 HC-$3.50 Plus Postage.
DESCRIPTORS Administrative Personnel; *Administrator Education; Health Facilities; *Health Occupations Education; Health Programs; Health Services; *Higher Education; Management; *Management Education; Management Systems; *Medical Services
IDENTIFIERS *United Kingdom

ABSTRACT

International comparative studies are justified because they can increase the options among which health care decision makers may select approaches suitable to their own circumstances. The collection of papers on management education and training in the National Health Service in the United Kingdom presents a summary of the salient features of the 1974 NHS reorganization and its implications for management education and training. A view of the range of training needs which can be met by a combination of internal development programs and relevant external courses is presented followed by examples of responses of AUPHA member programs in the UK to recent and future needs and opportunities in this field. Also included is a faculty list for the main programs collaborating in the provision of senior level management training courses in England and an abridged version of the current national policy statement. (JMF)

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PROGRAM NOTES

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NUMBER 66
DECEMBER 1975

EDUCATION FOR HEALTH SERVICES ADMINISTRATION IN THE UNITED KINGDOM

Donald K. White, Guest Editor

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EDITORIAL

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Health care systems, being unique historical products of the societies they exist to serve, are unlikely to be directly transferable across national boundaries. Yet international comparative studies - provided they comprehend the origins and environment of the systems reviewed - are fully justified if only because they can increase the options amongst which health care decision-makers may select approaches suitable to their own circumstances. This comes from fresh "outside insights" and liberation from the imprisoning mental process which sees ahead only in terms of those alternative futures currently being canvassed by the protagonists of opposing viewpoints. By way of illustration, if we accept for a moment that "accessibility to high-quality primary medical care" can move from the status of a slogan to that of a nationwide reality only by grasping the nettle of medical manpower distribution, then the means by which general practitioners in the UK are influenced as to where they set up practice might be worth more than a passing glance. This is not because the particular method used in the UK would necessarily be acceptable, in the USA for example, but simply because it comes as a revelation and stimulus to many that there <u>are</u> numbers of alternative mid-points between complete freedom and complete control in this matter which <u>can</u> be acceptable to the doctors concerned and - the acid test - move significantly towards the outcome desired by society.

Four working visits to North America over the past 10 years, involving teaching and research in the management development of health care professionals, have convinced me that the same is true of education and training strategies seeking to enhance the quality of our health care systems. They cannot be transferred, unmodified, across the Atlantic, for all kinds of historical, societal and psychological reasons, so we must avoid like the plague that form of evaluation which judges the activity of others by how closely it approximates what we ourselves happen to have done. But international comparisons can exert considerable mutual and highly beneficial influence - provided there is understanding of the unique context within which an education and training strategy has been fashioned, as well as the unique objectives to which it is contributing.

So a few words of explanation may be helpful in reading the following papers on Management Education and Training in the National Health Service. To set the scene there is a brief summary of the

salient features of the 1974 NHS reorganisation and its implications for management education and training. This is followed by a contribution from John Wyn Owen, administrator of a health district which includes St. Thomas' Teaching Hospital in London, who offers one viewpoint on the range of training needs which can be met by a combination of internal development programs and relevant external courses. Then come four papers illustrating the response of AUPHA member programs in the UK (at Birmingham University, Leeds University, Manchester University, and the King's Fund College) to recent and future needs and opportunities in this field. We then give faculty lists for the main programs collaborating in the provision of senior level management training courses in England (separage arrangements are made in Wales, Scotland, and N. Ireland) and this special issue is completed with an abridged version of the current national policy statement.

The policy statement was issued by the DHSS early in 1974 after an 18-month period of close consultation and detailed exploration of ideas with members and senior staff of health organisations, trade union interests, educators and others: nevertheless it is to be updated periodically so as to respond to changing circumstances and to counter the "tablets of stone" effect. Its distribution, in full or summary versions, was timed to accompany the structural reorganisation of the NHS in April 1974, which formally integrated the hospital, family practitioner and community health services. There was an intensive program of preparation and training specifically for that reorganisation and for the new roles which senior staff would find themselves holding: the continuing impact of this on the work of the program is fully reflected in the subsequent papers. The policy statement was addressed primarily to the 15 regional and 90 area health authorities which from April 1974 formed the basic organisational structure of the NHS. It was formulated for a health system which would demand of its managers a more sophisticated range of competences than before, both by reason of continued advances in the healing and caring sciences and their organisation, and because of the reorganisation itself which lays special emphasis on managing through multiprofessional consensus-forming teams, on the systematic planning of patient-oriented services and the setting and monitoring of performance standards, as well as on development of the human potential in our manpower resources.

The policy is firmly within the context of continuing management education, where the major concern is less with the professional preparation of new entrants to the NHS (including young administrators) than with the continued and progressive development of requisite managerial abilities amongst those, from all occupational groups, who find themselves in positions of management responsibility. In such roles their original technical expertise is of relatively little use in deciding, alone or with others, what to do and how to get it done. This is basically what we mean by management and is just as much a challenge for the head nurse on the nursing floor as for the administrator or chief of medicine in the boardroom; so our strategy has to be multi-professional and has to

see management education and training alongside other contributions to managerial development, such as performance appraisal, systematic opportunities for career movement to broaden experience, and study for appropriate qualifications.

The "philosophy" of Part B of the policy document is really not comprehensible except against this background, which explains the virtual absence of reference to higher degrees and long academic courses as a means of professional entry to the health service, or to hospital and health administrators more than managers from any of the other health care professions. We have started from a different position - that of giving priority in the allocation of training resources to the task of reaching very large numbers of experienced adult professionals - and since the mid-sixties, have with the advice of National Staff (Development) Committees, rapidly extended external training facilities to the point where currently every year 10,000 staff of the NHS attend management courses of two to six weeks' duration. Think for a moment of the implications for the teacher working with a group of health professionals with diverse backgrounds and rates of learning yet with broadly similar needs in continuing management education and a rich variety of experience that is in fact the major learning resource. The challenge of continuing education for the teacher of management is such as to recall Truman's advice, "If you can't stand the heat keep out of the kitchen!"

The papers from AUPHA member programs illustrate various responses to this challenge. Derek Williams offers a view of the corporate role of Birmingham's Health Service Management Center, which is of recent origin yet has enjoyed very rapid expansion. Keith Barnard puts a more individual perspective on the health care education scene, from within Leeds' Nuffield Center for Health Services Studies, which has a much longer history. And the King Fund's College, which has pioneered many new forms of management development for health care practitioners, is represented by a paper from Frank Reeves. Finally, Brian Watkin reviews the stages by which Manchester's Health Service Administration Unit has developed its present wide range of teaching activities.

As this selection of papers will show, the considerable program of NHS management education and training activity has been rapidly diversifying of late, away from exclusive reliance on individuals attending short general management courses and into the areas of team training, organisation development and consultancy, short intensive specialised seminars, management courses specific to clinicians, community physicians, planners, members of health authorities and local community health councils. More of this training is taking place at the workplace rather than in the classroom. There is, too, an accompanying research program based on the identification of management learning needs, the development of teaching materials and the evaluation of training effectiveness. All of this has produced, over the years, varied forms of collaboration between the NHS and the academic world in developing the required training, research and consultancy. At present the

Department of Health works directly with selected universities, business schools, and the King's Fund College on the development of senior NHS managers and graduate entrants to health administration, whilst the regional and area health authority training departments undertake middle, supervisory and in-service training in cooperation with polytechnics and community colleges.

Returning to my initial theme, this strategy of management education and training has evolved to meet the needs of a particular health system, a national system that makes possible certain features that would be impractical elsewhere. It has, however, already been influenced by achievements in other countries - for example the experience of continuing management education in Minnesota and Missouri and the research orientation of other AUPHA programs. Now, as we begin serious examination of the place in management development of longer courses leading to academic qualifications, it is good to have the interest and advice of colleagues working in other systems who have trod that path before.

And maybe they will find something of interest and value along our particular path.

NHS Reorganisation and Its Implications for Management Education and Training

This note summarises the salient features of the 1974 reorganisation of the National Health Service. It aims to provide enough information about the management changes that were then introduced or initiated tc help readers understand some of the recent background to the activities of British education centres working in this field. The main changes are identified, and some examples provided of the major and often highly controversial issues that were debated on management courses and more widely throughout the service. Plenty of more exhaustive accounts and critical commentaries are available in contemporary British health care journals. The standard introductory official document is 'Management Arrangements for the reorganised National Health Service' (HMSO 1972). A useful summary of the philosophy and framework of reorganisation is provided by Burbridge's five short articles in 'Health Trends' (vols. 5 and 6, 1973-4). The accompanying diagram is taken from the fourth of these articles.

Immediate, dramatic improvements in the quality of health care were not expected from reorganisation. By streamlining its management arrangements, and integrating previously separate parts of the British health care management system (the old 'tripartite' system of hospital, local authority and general practitioner services), the NHS was to be given the capacity to increase its long term effectiveness. But there was some disagreement about the extent to which reorganisation would achieve this aim: some feared that decision-making in the new service would become more bureaucratic and centralised; others anticipated the reverse, quoting the central principle of "maximum delegation downwards matched by accountability upwards" that had been enshrined in the official literature of reorganisation. Certainly, there was considerable streamlining of the formal structure. Fifteen Regional Hospital Boards, 330 Hospital Management Committees, 36 Boards of Governors of Teaching Hospitals, hundreds of local authority health departments and executive councils for the family practitioner services were replaced by 14 regional health authorities and 90 area health authorities covering some 200 'health districts', each with its multidisciplinary district management team. But no one claimed that all the aims were or could be fully or immediately achieved. The hospital and local authority health services were, for example, integrated at the expense of making an awkward 'interface' problem between the new health authorities and the equally new matching local authorities:* complex mechanisms had to be created to provide for collaboration

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*In England and Wales, new local government and health authorities came into existence on the same day: 1st April 1974.

between health, social services, education, housing and the other agencies and interests of local government. Moreover, as the accompanying diagram suggests, the new arrangements looked formidably complex at first sight. The major changes included:

i) A complete new system of regional and area health authorities, whose membership and functions were the cause of considerable debate. Broadly, these authorities are expected to set policies for the service, within the limits of higher policies, and to review the implementation of these policies. Each is assisted by a team of officers and supporting staff but the main line of responsibility, as the diagram shows, is from AHA to RHA to Secretary of State. The inter-tier officer relationship is described as a 'monitoring and coordinating one': many observers were uncertain about what these arrangements meant for the officer-member relationship. Some were also concerned about the number of management tiers between the patient and the DHSS, and called for the removal of one or another level. Some debated the wisdom of creating authorities whose members were appointed rather than elected. (Membership of the authorities is currently being changed to provide for greater local authority representation.)

ii) An officer system of regional, area and district management teams, each with its supporting staff of administrators, nurses, community medicine specialists and others. These teams are consensus-forming groups of equals, with no one member having executive authority over the others. Membership of the various teams is as follows:

Regional Teams of Officers	Regional Administrator Regional Medical Officer Regional Nursing Officer Regional Treasurer Regional Works Officer
Area Teams of Officers	Area Administrator Area Medical Officer Area Nursing Officer Area Treasurer
District Management Teams	District Administrator District Community Physician District Nursing Officer District Finance Officer + a consultant and general practitioner (see below and the diagram)

For the great majority of senior officers in the service, reorganization brought considerable personal and professional change. Virtually everyone had to change his job: at the very least, to compete publicly for its nearest equivalent in the new service. For some professions, the changes were massive.

A new medical specialty of 'community medicine' was created during the course of reorganisation and, for many former medical administrators, entering the new specialty and adjusting to their new roles meant more or less simultaneous change in their professional, social, managerial and political circumstances. For others, the same kind of difficulties manifested themselves in less acute forms - administrators, nurses and treasurers all had to face subtle changes in formerly similar positions, and at the very least had to learn to live with the requirement for 'consensus'.

iii) A clinician representative system was introduced which involved hospital doctors and general practitioners in management in a variety of ways. Some problems resulted: one of the most difficult has been to define the contributions that might be made by the clinician members of the district management team, who are there in their capacities as chairman and vice chairman of their District Medical Committee. How free are they, for example, to bind the clinicians whom they represent to management decisions? Are they delegates or representatives?

Other features of the new structure included the introduction of Community Health Councils to represent the interests of the consumer; mechanisms for collaboration between health and local government authorities (see earlier); and professional advisory machinery.

But perhaps the most important single feature of reorganisation was the intention to introduce a new planning system which would give life to the whole structure and make possible the devolution of real influence and initiative to the district level and below. Within each district, health care planning teams were to be established, to consider the needs of particular groups in the community: the elderly, the mentally ill, etc. Their membership would be broad and flexible, and could include not only NHS officers and clinicians, but also those who had contributions to make from outside the service, e.g., social workers, housing managers, representatives of voluntary bodies. In formulating their district plans the District Management Teams would consider health care planning team proposals and the views of other bodies within the district: there would then follow a cycle of inter-tier negotiations - district, area and regional plans being agreed in turn, financial allocations and planning guidelines passing the other way. In many districts, health care planning teams are now working well, but unfortunately the introduction of the planning system itself has, for various reasons, been delayed. Until this system is working, reorganisation cannot be said to have taken effect. It is, of course, now clear that reorganisation did not take place on 1st April 1974. The new authorities then came into existence, but the structural changes outlined above can only be of value if they lead to greater role and process effectiveness. This will take time to materialise.

Later papers in this issue will review some of the contributions made by the British education centres to meeting the training needs of reorganisation. This effort is still continuing, for example, in the provision of short courses for those charged with introducing the new planning system and seminars to examine the problems of collaboration between the health service and local government. More generally, the structural changes reviewed above have not been completely matched by attitudinal change. Some of the basic concepts of the new service, e.g., 'consensus', 'accountability', the 'monitoring' responsibilities of one role vis-a-vis another, are sometimes misunderstood or viewed with suspicion by NHS officers.

Management educators can and do help here, in a number of ways: by facilitating study and discussion of the key concepts, by proposing and helping NHS officers to consider alternative interpretations; by developing 'consultancy' relationships with individual authorities; by more fundamental research into troublesome issues. But it is the strong commitment to decentralisation that will probably be the greatest influence of reorganisation upon management education and training in the NHS. This commitment has not yet been given much practical expression, but this will surely come: later papers in this issue discuss some of the likely consequences.

EXPECTATIONS OF HEALTH SERVICE MANAGEMENT EDUCATION AND TRAINING - A DISTRICT PERSPECTIVE

John Wyn Owen
District Administrator
St. Thomas' Health District (Teaching)

INTRODUCTION

The main contributors to this series have been preparing staff for health service management for many years. This paper looks at the education and training of health service managers from the receiving end where the perspective is that of a local health district - and one where functional management has been introduced District-wide. Further, it is a Teaching District in London where there is serious interest in the training and education of all health professionals, including the development of their management abilities. Recent emphasis in the reorganisation of the health service on management and planning at District level means that all facets of health care management are present to a lesser or greater extent in Districts. This paper examines the role of the District Administrative organisation, the preparation and training of staff in post, the shortcomings identified "in house," then more generally the management education and training of health professionals.

ST. THOMAS' HEALTH DISTRICT

The St. Thomas' Health District is one of four in the Lambeth, Southwark and Lewisham Area of southeast London. There are about 200,000 people living in the District. This population currently uses a range of London hospitals and this is unlikely to change radically after reorganisation. The main hospital in the District is St. Thomas' which has teaching and research responsibilities and serves people who are widely dispersed geographically, but there are altogether seven separate hospitals, health centres and clinics in the District.

Corporate responsibility for the delivery of health services in the District rests with the District Management Team - two representatives of the District Medical Committee (a general practitioner and a consultant), the District Community Physician, the District Nursing Officer, the Dean of the Medical School, the District Finance Officer and the District Administrator.

THE DISTRICT ADMINISTRATIVE ORGANISATION

The immediate minimum aim of the District administrative organisation has been to ensure continuity of services, both in the hospital and in the community, during the upheaval of reorganisation. It has a major part to play in stimulating the process of integration between previously separated health care centres and bringing about fundamental change in outlook and attitudes by continually emphasising the concept of the reorganised National Health Service, which is concerned with people and not just with patients.

In its new role the Administration has increased opportunities and broader responsibilities to think, plan and operate in a wider context than hitherto, so as to encompass both community aspects of health care as well as purely hospital based services, functions and activities.

FUNCTIONAL MANAGEMENT

Over the past five years, the main part of the District's management burden - St. Thomas' Hospital - had been developing the concept of functional management, and the new administrative structure for the District had been developed along similar lines, firstly because the complexity of the National Health Service is now such that increased effectiveness can only be derived, it would seem, from increasing specialisation. Further, functional organisation should lead to increasingly uniform standards of operation throughout the District and prevent the development of competing standards which are wasteful of resources. Thirdly, increased emphasis on direct line management should provide greater operational control over the services being provided. The case for geographical organisation (a separate general all-purpose administrator at each unit hospital or group of health facilities in a geographical sector of the district) rests mainly on the arguments for coordination of services at the lowest possible level, but this is not necessarily incompatible with the concept of functional organisation which has the added advantages outlined above.

So far, the National Administrative Training Scheme - a two-year scheme for the preparation of graduate recruits for a career in health administration, functioning since 1956 - has been geared to developing generalist administrators to operate on the basis of a geographical unit, whilst systematic training for the management of specialised administrative functions is very difficult to acquire, on entry to the NHS or subsequently. Functional management makes demands, therefore, which cannot be met by the existing recruitment, training and development programs.

The administrative organisation of a District can be seen to have a broad but distinct division of functions into two categories. Firstly, there are those essential support functions which any institution that caters for residential care would need - maintenance, personnel, hotel and supply services. These are largely line management functions. Secondly, there are those health functions which the District specifically exists to provide. These are concerned with the planning and implementation of services bringing care and treatment to the patient and individual in the community. Here, the role of administration is not one of purely line management, but is rather one of joint planning, liaison with and coordination of a wide range of medical, nursing and community services which present the new District administration with a major challenge. The risk of fragmented uncoordinated services with their often conflicting and competing claims on resources are minimised by incorporation of all patient care services within a single administrative unit.

There are in the St. Thomas' Health District eight functional divisions - works, management and computing services, hotel and supply, planning and development, personnel, scientific services, treatment and amenity and clinical support; the last three are regarded as the patient services group.

SECTOR ADMINISTRATION

The District is large and 20 million pounds is spent maintaining the operation each year. The District employs 7,000 people, and there are obviously problems of coordination below the District Management Team. It is believed that the concept of functional administration should be capable of extension to the lowest level of the organisation. The District has therefore no career post of the traditional generalist hospital administrative type, working in geographical sectors. The existence of separate institutions does, however, place strain on the functional organisation. Because of the sheer size of the patient services aspects and the need for local on-the-spot representation of certain functions such as medical records, there is likely to be a senior member of the patient services group in each of the hospitals of the District. In the administrative organisation, he assumes further responsibilities for accompanying members of the Community Health Council, providing first-line contact with the press and public, and examining all services provided within his institution from the patient's point of view.

EDUCATION AND TRAINING OF ADMINISTRATORS AT ST. THOMAS'

The successful implementation and operation of the new St. Thomas' District, indeed the capacity to achieve the objectives of the entire reorganised National Health Service, depends upon the managerial abilities of the administrative staff and others. In the District it was considered that, in addition to the advantages of functional management mentioned earlier, two other elements should be borne in mind. The first is the climate in which middle management could develop specialised functional skills and also form a nucleus of suitable candidates for promotion to more senior administrative posts. The second is the challenge of improving career opportunities for specialist administrators.

In the District there have been opportunities for individual staff development, comprising visits to other institutions in both the UK and overseas (particularly exchange visits arranged with the University of Chicago hospitals); attendances at various National Health Service courses at first-line and middle management level, run in conjunction with the training office of the Regional Health Authority; and limited representation on courses at other external training establishments such as the London Business School and Manchester Business School, institutions which are not specifically geared to the special characteristics of the Health Service. National administrative trainees have also been recruited to the District. Senior management development courses (6-week), experienced senior managers courses (2½-week), and specialised seminars (3-5 days) are held at the university education centres and the Kings' Fund College.

Doubts have been increasingly expressed of late by many senior managers that a great deal of off-the-job management development has not always been sufficient, in itself, to be relevant to the needs of the hospital or District or individual managers, nor have they resulted in tangible improvements in managerial performance. It is also arguable that they have not generally enhanced the ability of managers to make a practical contribution towards operational problem solving, particularly that of a multidisciplinary nature. The courses have also not made a significant contribution towards improving communication. Generally, off-the-job management training has failed to prepare management adequately for the fundamental changes of attitude required by reorganisation.

However, it may be that the benefits which should have been derived from these activities were to a large extent dissipated through personal inertia or the lack of support from their seniors or an excessive workload upon managers on their return to their working environment.

The new management organisation has gone some way towards distributing work more evenly between functions, but this in itself will not be enough to promote managerial effectiveness. What is required is a comprehensive development program for managers which will enable them to become involved and committed to a program of action in their functional area, use their time more efficiently and develop confidence through achievement of tangible success.

To achieve this, people must develop firstly analytical skills such as decision making, problem solving, use of management information, measures of performance, planning, organisational theory, systems design and methods improvement; and secondly, behavioural or people-orientated skills such as motivation, communication, monitoring, delegation and staff development.

In the District, some of the training needs will be met by facilities available within the National Health Service, by centres such as the King's Fund, and by courses of the type mentioned by other contributors. These the St. Thomas' DMT have considered essential but they must be supplemented by in-house training modules specifically for St. Thomas' in order to develop and design personal development programs for individuals and for multidisciplinary groups who have similar problems and training needs. In order to meet the identified deficiencies in the administrative organisation, to make use of external training courses which members of staff have already attended, and to help other managers who have not been on management courses, an in-house management development program is currently under way.

Naturally for the District the main objective of this in-house management development program will be quantifiable results which indicate improved performance in different areas and in total. Of equal importance is the benefit that individuals derive from being involved in such a program, from being assisted in managing more effectively and from confidence in their ability to manage. They will benefit from their improved management skills both at St. Thomas' and if they move to other positions in the Health Service.

In the District the following areas for improvement were identified: communication; adaptation to change; generating change; planning costs; delegation and accountability; confidence and skills.

The in-house management development program was installed for 200 selected management staff. It was to be in-house to ensure that management theory was related to the realities of the operating situation. As part of that program, simple measures of management performance were to be developed to monitor progress and provide quantifiable evidence of success. The initial program would lead to a continuing commitment to management development as a priority in routine managerial activity.

The in-house program has six main stages - the identification of development needs, the preparation of educative material, management seminars, developing measures of management performance, practical application and project management.

CAREER PROGRESSION

Career progression is equally important. The recruitment and training patterns generally in the National Health Service have not been attuned sufficiently to cope with management structures such as ours. Planning, personnel, and management sciences are new activities; so are integrated works departments. For example, recruits to the national administrative training scheme will have no specialised knowledge. If they join St. Thomas' from the national scheme, then they must decide which function to specialise in and must pick up detailed knowledge in order to be able to contribute effectively, even at the lowest level, to the management of that function within the District Further, other specialists who have been recruited or trained within the District have little opportunity at present to progress to general management positions.

In a recent DHSS circular on computing, for example, the prospects of progression and the lack of progression to date by computer personnel were shown to have been less than satisfactory. Hitherto, specialist managers have not been able to progress to general management positions outside their own field, despite demonstrable managerial success by individuals in their own professions. The success of the health service in the future will depend on being able to recruit specialist managers whether in catering, laboratories, nursing, personnel, computing, works or planning, and enable them to compete for the post of District Administrator on an equal footing with other staff recruited from schemes such as the national administrative training schemes.

At St. Thomas' we have appointed a senior administrative team where the Director of the Department of Computing Science is an engineer, experienced in industry as well as in the health service; the Director of Personnel was recruited from business; the Planning Director was an administrative trainee with an interest in information who, with the encouragement of his staff development officer, undertook a higher degree at a university; the Director of Administration of Scientific Services was an administrator whose background included scientific services administration in the Ministry of Defence; the District Hotel and Supplies Administrator was previously the catering officer. The health service is large enough to recruit and develop people for all these functions. But the task of career development is not complete until opportunities for further advancement into top-level general management have been opened up for such functional managers.

DEVELOPMENT OF MANAGERS IN THE NHS TO DATE

What is required today is management development that will produce prople able to build new forms of organisation rather than simply operate within existing forms. That will enable the health service to cope effectively with change. This implies planning, generating innovative ideas, imaginative leadership, the establishment of new procedures, the development of new abilities and skills among people working in the health service, and initiation of new ways of health delivery.

Much of the present-day provision for management education and development in the National Health Service is very different from this. It is a patchwork of appraisal schemes, succession plans, a little career planning, and training courses external to the operation.

So far in Britain we have concentrated our efforts on the management training, rather than education, of health service personnel. There have been comprehensive arrangements for recruitment and the development of management skills and practice as part of an integrated career structure for administrative staff. However, so far we have been training individuals in subjects of immediate relevance to the specific jobs they are doing or about to do, and taking a global view of administrative training in the health service, it has so far been carried out on a rather piecemeal basis.

The main concern must be to provide intellectual tools to help managers to relate economics, epidemiology and those aspects of social psychology which deal with motivation and morale; and to explore the relationship between these factors in different types of organisation. Managers should also be encouraged to think as far as possible in quantitative terms without at the same time becoming uncritical quantifiers of non-quantifiable information. Health service education should be based on principles of logical and orderly thinking which can be applied to new situations and circumstances as they arise, rather than just the accumulation of specific information on operation and past experience which quickly becomes dated.

With increasing emphasis on community health services, collaboration with local government in neglected service areas such as the care of the elderly, the disabled, the mentally handicapped and the mentally ill, effective management, planning and community participation, we must consider educating our health care administrators in the basic concepts of administration sciences. General intellectual skills and the ability to devise, evaluate and implement imaginative programs will be particularly important for the future of the NHS.

The wide role which in practice the British health care administrator - in his various forms: a person who runs a hospital, a senior nurse, an epidemiologist (the community physician), health planner, finance officer - is required to fulfil, and the current heavy emphasis on internal cooperation, suggest that it is essential to develop a planned and coordinated structure within which all managers, whatever their difference of discipline or professional background, can be assured of an interrelated and continuing educational experience in their organisational role.

In a system which is to be numbered among the ten largest organisations in the world, it seems tragic that those responsible for the management should still be trained in separate pigeon holes which at present are sometimes a little better than hand to mouth. The roles of administrators need to be reviewed, defined and firmly established. Meanwhile, trainee administrators who will in due course occupy important and responsible posts in the health service should begin with a broadly based educational program. A sound intellectual framework within which they can make decisions is essential.

CONCLUSION

This paper has identified some of the key tasks of senior administrators in the health service. Whereas it has been stressed that administrators in the health service perform a variety of functions, if one considers the main administrative organisation of a District of the kind described, there must be a strong case that the senior post of District Administrator should be filled from amongst staff who have proven managerial success and not necessarily from amongst staff recruited from university who have passed through a graduate training program. I believe that many of the professions have experienced managers who, given appropriate opportunities, should confidently and capably command the most senior positions. This means that initially staff will be recruited for their specialist contributions to the operation. This can range from catering to nursing to laboratories.

Early in their career, staff should have an introduction to the general principles of management, stressing the analytical skills and the people skills. In-house management development programs, coupled with external courses run by health authorities and academic institutions, should supplement the professional specialist knowledge of the various staff, and of crucial importance is the ability to develop analytical skills in administrators. This will depend on whether individuals are destined to perform at middle or top management level. Staff who have this potential, irrespective of professional discipline, should be identified. The training and educational facilities should have a strong research base. This suggests either a university, a business school or a polytechnic. There are advantages for staff to be trained with people from industry as well as other professions within the health service. It is important that there should be opportunity for up-dating the skills of NHS manager at all levels. This can be done either through locally organised study days or through short seminars run by training centres. The question of whether staff should go on short or long courses is important, and this has not so far been investigated, though there is undoubtedly room for the selective use of both, depending on individual need and aptitude. Most of the managers in the District have been on short courses. Given, however, that management is a complex and demanding intellectual discipline, the senior administrators should have an opportunity of attending courses up to two years in length. One of the key tasks that faces management is the ability to identify amongst subordinates those with potential for higher management responsibilities.

MANAGEMENT EDUCATION AND TRAINING IN THE REORGANISED NHS - A PHILOSOPHY AND A POLICY

A 12,000 word policy statement with this title was circulated widely, early in 1974, within the National Health Service (NHS) and amongst the Universities and Colleges which cooperate with the NHS in its management development program.

Timed to coincide with the formal integration (effective April 1, 1974) of the three branches of the NHS - general practitioner services, community health services and hospital services - this statement examines management education and training arrangements as they had developed in the existing NHS and offers a set of seven principles on which such needs should be met in the reorganised Service. In an appendix* are formulations of suggested objectives for management development at first-line/supervisory middle and senior levels in the NHS and areas are identified where further study and experiment are needed to help lay the foundations for further development. The memorandum is addressed primarily to those who have a major, specialised responsibility for NHS management development, but in order to encourage widespread understanding of this policy a summary of the main points of the memorandum was separately distributed together with an outline of priorities for the academic year 1974/75, the intention being to update the guidelines as requirements in health care management change and as fresh insights and research findings emerge: accordingly the guidelines for 1975/76 were circulated in the Spring of 1975.

The purpose of this abridgement is primarily to emphasise the major principles of philosophy and policy set out in the memorandum. This inevitably carries the risk of some distortion, insofar as the bulk of the supporting detail is necessarily omitted; whilst the context within which these principles have been defined - through an elaborate process of consultation, investigation and reviewed experience - can be no more than hinted at.

Part A: The Present Situation and Future Need

This part of the memorandum sees the purpose of NHS management education and training as being the same as that of other aspects of management development - to help improve the quality of management and thus to contribute to better health care, both of individual patients and of the community as a whole, within available resources. Health care is provided predominately through people

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* Available to enquirers from the editor at the D.H.S.S., 157-168 Blackfriars Road, London SE1 8EU, England.

and, in an 800,000-person organisation like the NHS, the development of its human resources to their highest potential, in the pursuit of the Service's health care objectives, represents the essential interests both of the individual employee and his organisation. This is the particular province of the personnel function and, within that context, "management development" is the general term which embraces a number of strategies (including appraisal and counselling, management education and training both on and off the job, the systematic acquisition of varied experience, study for appropriate qualifications, team training and Organisation Development activities) designed to develop in an orderly way the managerial capacity of an organisation through its members.

Consequently it is the clear responsibility of the NHS authorities to facilitate the development of all their staff, including all their managers. Some idea of the scale of this task can be gained from the fact that the number of NHS officers who have managerial responsibilities of a significant nature - from first-line supervisors to chief officers in all professional and occupational groups‡ - is in excess of 100,000. The management ability of all these personnel has for the most part to be developed within the NHS itself and, although the foundations for this logically need to be laid during their basic technical training, the major thrust must be one of <u>continuing</u> management education as a career-long process, offering management understanding and management skills as the health care professional has the need of this help and has the opportunity of applying it directly in his work.

Against this background it is not surprising that priority in the allocation of resources has been given so far to post-experience management training courses, based on the recommendation made by National Staff (Development) Committees. The scope and scale of this activity built up rapidly in the late sixties and, under the auspices of Regional Health Authorities, at first-line and middle management levels each year over 10,000 staff spend from a few days to a month or more on management courses for an increasingly wide range of hospital and community health staff. At senior level, courses have been provided on a national basis at the King's Fund College and certain Universities, in the form of 6-week senior management development courses, 3-week courses for experienced senior managers and short specialised seminars on specific management topics. Originally such courses catered for administrative staff only but, following the introduction of a systematic nursing management structure, from 1968 places were provided for nurses and midwives and the courses are now open to members of all professions and occupational groups in the NHS.

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‡ for example we recognise an important management component in the work of the ward sister/head nurse.

But experience gained from these courses and findings from research* both inside and outside the NHS demonstrate that attendance at an off-the-job management course is not of itself sufficient to ensure effective learning and its application in improved management at the place of work. A great deal depends too on the "climate" within the parent organisation, recognition of the value of training by senior management, the quality of officer relationships and the involvement of the student's senior officers, particularly in his preparation for the course and in follow-up on his return. Recognition of these factors would in itself require a re-appraisal of overall management training strategy in the NHS, but the reorganisation of the Service adds further training needs through the central emphasis placed in that reorganisation on such functions are:

- consensus-forming management and planning teams;
- new planning, information and financial control systems;
- the need to monitor performance against objectives and standards;
- the growth of the personnel function;
- securing effective integration of health and social services.

An appendix to the policy document attempts to reflect this in the process of defining requisite areas of managerial competence, such an attempt being regarded as essential in providing a framework for agreed management development objectives, systematic analysis of training needs, a firm basis for curriculum development, a criterion for student eligibility and a yardstick for evaluation.

Part B: Principles for Management Education and Training in the Reorganised NHS

This central part of the memorandum offers seven principles to provide an underlying sense of direction for a long-term strategy for management education and training. Although the pace of development will inevitably depend in large measure on the availability of resources, each year's set of guidelines for action must represent a step in the right direction: it is therefore essential to be clear what that direction is, so that the attention and efforts both of the NHS and of relevant parts of the academic world may be similarly aligned. The following propositions were therefore set out as signposts, indicating that the management education and training strategy should aim to become:

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* amongst those whose work has specially influenced recent thinking about management education and training in the NHS are Professors Chester, Revans and Jacques, Derek Williams, Julia Davies and Alistair Mant.

Comprehensive

It should extend to all health care personnel with managerial responsibilities, irrespective of their occupational groups, as teams and as individuals. Provision should eventually cover both occupational management training (focussing on the management of one function or closely related group of functions) and multi-professional management training (focussing on abilities needed by all NHS managers, and recognising that most management problems in health care are soluble only by collaboration between members of a number of professions or departments, so that NHS staff who manage together should wherever possible learn together). These two main forms of management training are seen as complementary and at any particular stage of an individual's development one or the other might properly predominate.

Integrated with Work

Management is not seen as a distinct body of knowledge that can be learned like a discrete academic subject. Whilst drawing on a very wide range of theory for its concepts and techniques, the real meaning of management is not learned until it is experienced by actually managing. And as the student experiences it the meaning deepens, so that meaning and experience are continuously feeding into each other. Consequently the task of management education and training cannot be discharged fully through the contents of an external course, however high its quality: the process begins and is continued at the work place rather than the classroom. Where special relationships emerge between sources of management teaching expertise and particular health authorities and teams of health professionals, the work place/classroom gap can be bridged by focussing training on the practical problems of management faced in daily tasks, by making explicit links between theory and practice, and by helping the manager to learn how to learn. Without this capacity to learn, experience fails to teach.....

Formal management training (e.g., through off-the-job courses) is neither an automatic right for every manager nor a necessary precondition for effective management: it is only one means of developing necessary competence which should be considered alongside others such as performance appraisal and counselling, on-the-job coaching, the systematic acquisition of varied experience, participation in special assignments and in group training within the parent organisation. There is a major need to increase amongst NHS managers the capacity to identify the development needs of their subordinates and to meet them as far as possible at or near the place of work. Where, however, an off-the-job management course is judged to be essential, the active support and involvement of the course member's immediate superior is a vital ingredient for successful training and will need to be expressed through careful assessment of training needs, specific preparation and briefing before the course, participation in the choice and support of projects and action plans, and de-briefing and follow-up after the course. Ultimately management - like much of clinical

medicine - is a practical art in which progress is made largely by constant performance under the guidance of a trained and experienced practitioner.

Progressive

Each stage of management training, whether occupational or multi-professional, should consciously provide a foundation on which the next stage can be built in a career-long process which should logically commence during basic technical training as part of preparation for initial management responsibilities. It is important that specific learning time should be recognised as a legitimate feature of any manager's job and ultimately not more than, say, five years should go by without some form of training being at least considered for a manager, on or off the job.

Collaborative

Greater effectiveness in management education and training requires closer links between the student, his immediate superior, his parent organisation, and the trainer or teacher. Freer movement of staff between the Health Service and educational institutions is being given further encouragement, and stronger links are advocated between NHS authorities and those universities, polytechnics and colleges which are invited to make teaching, research and consultancy in health care management a major commitment.

Related to Organisational Needs

The manager's accountability for contributing to the objectives of his organisation is the basis of his learning needs. It follows from this that health authorities must define their objectives and the contribution towards meeting them which they expect from management education and training. Since health care organisations are so varied it is highly appropriate for much of the required development to take place within the organisation itself. In this area a great deal has been learned of late about the effectiveness of newer forms of training (such as participative management, local problem-solving groups, team training and organisation development activities generally) which are brought to bear on the unique needs of complete organisations, teams and services, rather than of individual managers.

Related to Individual Needs

Adapted to the varying strengths, needs, aptitudes and pace of learning of each individual manager. These differences of need can most readily be taken into account through on-the-job coaching and training, where local circumstances are favourable, but even on an external course there are opportunities for:

- split-level teaching (basic and advanced work in parallel);
- use of options and electives to meet individual requirements;
- individual and small group tutorials;
- unallocated time for use as course members' needs dictate;
- the development of self-paced learning such as programmed instruction and guided reading.

However, even before the manager reaches the classroom as a student, much can be achieved by the careful analysis of his job and the identification of specific areas of management performance in which he requires strengthening. These can form the basis for a statement of training needs, agreed between the manager and his superior, which the trainer needs to know if he is to help the available learning opportunities relate and contribute to greater management competence for each individual student. In any case involvement in off-the-job management development should not be sought lightly or automatically: nominations should be made only for training from which the participants are really likely to gain something valued highly by the organisation as well as the student. There is no virtue in training for its own sake and there is thus no point, for example, in attendance at a course designed to develop management skills which the student already possesses to an acceptable standard.

Monitored and Evaluated

To ensure that the heavy investment of resources (including the valuable time of students and teachers alike) in the current level of NHS management education and training produces the highest possible return in the form of better management of health care services. This implies that, in spite of the undoubted difficulties, systematic and widespread evaluation must be attempted - not merely on a research or demonstration basis - in order to assess the effectiveness of the training and guide its further modification and improvement. Ineffectiveness in management development has frequently been traced to the vagueness, or sometimes the complete absence, of objectives, whether of an individual teaching session or an entire training course, or in the minds of students themselves. Whilst attempts at evaluating the end-of-training reactions of students to its content and conduct are now virtually routine and have some place in an overall evaluation strategy, policy is currently being influenced by a number of evaluation studies completed or in progress at the outcome level of evaluation, where the attempt is to assess how far actual management performance has changed on the job some time after training and as a probable consequence of it. There is clearly a great deal of work to be done in defining instructional objectives in terms of what the student should be able to do at the end of

training and indeed on defining the standards of working performance expected of managers. At the same time it is vital that due importance is given to the less tangible effects of training (including the development of critical reflection, analytical approaches to management and creative attitudes) so that evaluation - the comparison of performance against objectives - must avoid the danger of seizing on the measureable at the expense of the unmeasureable. This is one aspect of the general responsibility for monitoring performance against previously agreed objectives - in training as in other functions of health care organisations - which will ultimately apply throughout the reorganised NHS. No progress can be assessed towards an unspecified goal. .....

Part C: Considerations Affecting Further Development

This final part of the policy statement identified a number of requirements for further study and future progress in NHS management education and training, including:

- more systematic analysis of learning needs, of individual managers, teams and entire organisations;

- collaboration with Local Government to promote understanding of health care management in its wider social and community context;

- study of the place of Organisation Development activities in NHS management development;

- more systematic liaison arrangements between the NHS and the academic world;

- more effective involvement of the medical profession in forms of management development relevant to their varied roles;

- development of future management educators and trainers to support the level and variety of activity envisaged in this memorandum.

Studies and experimental developments are now in progress in all of these areas, although space does not permit details to be provided at this stage. Another study, now approaching completion, is that of the place of long courses (leading to specific management qualifications, for instance at Master's Degree level) in the overall strategy of NHS management development. This includes an attempt to establish criteria which can be used to identify those who are most likely to gain - both for themselves and for the NHS - the fullest available benefit from a longer academic program, those courses of study which are most likely to provide

such benefits and those educational centres which are best able to meet any such requirements from the NHS. The major emphasis in the NHS so far has been placed on short, job-related episodes of management training at various career stages and management levels: the strategy has been primarily one of continuing education and in this way very large numbers of NHS managers have been reached. However, time is an essential factor in the development of managerial competence to the high level required for senior managers to operate successfully in the reorganised Service; and the "backlog" has been overcome through the continuing education strategy to the extent that the complementary contribution of longer courses of study to the future needs of the NHS can now be seriously examined. The experience gained in other countries where the reverse priority of emphasis has been placed, for the most part, on long courses rather than continuing education in management, represents one valuable source of material for this study.

Finally the memorandum recognises that high-quality management education and training cannot be developed without adequate resources, including finance and an adequacy of staffing levels within both the health care organisations and the educational centres with which they collaborate. For example, the infrastructure of a personnel and training service is gradually being built up locally within health authorities, making it possible for increasing attention to be paid (as advocated in this memorandum) to forms of management development closer to the operational level of health care management. The availability of resources will always be one of the major influences on the rate of progress in the directions indicated in this policy statement, but it is noted that almost every development advocated is already being practised somewhere in the existing NHS. The challenge is to make these good practices universal.

HOSPITALS AND HEALTH SERVICES YEARBOOK

The 1975 edition of the Hospitals and Health Services Yearbook has just been published. It contains the names and addresses of the new health authorities and health districts, chairmen of authorities, teams of officers and other senior staff and particulars of hospitals, day hospitals and health centres and community health councils. There is a section listing independent hospitals, insurance schemes, national organisations and even a short bibliography of health service literature. The total Directory is 1,094 pages and the cost is $40.00 by surface mail from the Institute of Health Service Administrators, 75 Portland Place, London W1N 4AN.

NATIONAL TRAINING COUNCIL FOR NHS

A National Training Council has been established for the National Health Service and held its first meeting in October 1975. The chairman is Mr. D. A. Perris MBE JP, chairman of West Midlands Regional Health Authority.

The Council has been appointed by the Secretaries of State for Social Services and for Wales to advise them on the general strategy, development and co-ordination of training for the NHS and on training needs common to different staff groups.

The Council will work closely with the National Staff Committees for the National Health Service and will take full account of the responsibilities of the statutory and professional bodies concerned with the education and training of certain staff groups.

The establishment of the Council, like the recent establishment of four National Staff Committees, forms part of plans for providing the NHS with comprehensive central advisory machinery in the fields of training, recruitment and staff development.

At the first meeting the Council set up a Standing Committee on Management Education and Training, as well as a Working Group on Educational and Training Methods and Technology. The former has, as one of its first items of work, begun consideration of a report by Mr. D. K. White, the Department of Health's management education adviser, on the possible place of a master's degree in health care management in the development of senior NHS managers, and a report* by the Business Graduate Association, recommending the establishment of such programs at graduate business schools.

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* To be reviewed in a future issue of Program Notes.

NATIONAL TRAINING COUNCIL FOR THE NATIONAL HEALTH SERVICE

CHAIRMAN

D A Perris MBE JP	Chairman, West Midlands RHA

MEMBERS

Mr A J Brooking MA FHA	Regional Administrator, South Western RHA
Dr Vida Carver	Tutor, Open University
Mr J Constable FICE, ARICS, M1 MunE	Regional Works Officer, West Midlands RHA
Miss M J Cooper SRN SCM RNT	Chief Education Officer, General Nursing Council
Ø Dr T McL Galloway MD FRCP(Ed) FFCH DPH	Area Medical Officer, Hampshire AHA (T)
Mr J W Glendinning BA	Chief Training Officer, Local Government Training Board
Mr J R Gourlay MA AMIHSA AMIPM DIP IET	Regional Personnel Officer, Wessex RHA
Ø Miss C M Hall CBE Hon.D.Litt SRN SCM NA(H)Cert	General Secretary, Royal College of Nursing
Dr R E A S Hansen MA MB B.Chir DPH RGPS FFCM	District Community Physician, Cheltenham District
Dr R Maggs MD FRCPsyc DPM	Consultant Psychiatrist, Hellingly Hospital
Mrs M J McCarthy	Member, Oxford RHA
Mr P J C Perry OBE BScEcon	Director of British Association for Commercial and Industrial Education
Mr A H Phillips MBE AMBIM	Regional Education and Training Officer, SW Thames RHA
Ø Mr C H Preston Robinson FPS DBA FHA FCS M.Inst.PS	Lately Group Pharmaceutical Officer, Kings Mill Hospital, Sutton in Ashfield, Notts.

Mr K Punt FCA IHA IPFA	Area Treasurer, Leicester AHA(T)
Ø Dr J Rusius FRCPath DCP (Haematologist)	Morbid Pathologist, Burnley General Hospital
Mr B Saunders MHCIMA	Group Catering Manager, Mid-Surrey District
Mr P A Smith FBOA AMCT	Secretary, British Optical Association
Mr C C Stevens OBE L1B FPS	Chairman, Cheshire AHA
Mr T H Waterhouse L1B	Legal Adviser, West Midlands RHA
D T E Williams BA PhD	Director of Health Services Management Centre, Birmingham University
Mr R W J Wood	Chief Executive Officer of Wool Jute & Flax Industrial Training Board

Five further members have yet to be appointed including two from Wales.

Secretary V F Jones	Department of Health and Social Security Room 410 Friars House 157-168 Blackfriars Road London SE1 8EU

Ø Nominated by the Staff Side of the General Whitley Councils for the Health Services (Great Britain).

KING EDWARD'S HOSPITAL FUND FOR LONDON

Working Party for a Review of Senior Management Training in the NHS

The National Health Service employs more than 800,000 people in a complex enterprise of the greatest importance to the national well-being. The cost annually to the tax-payer is of the order of 3,000m. pounds, representing some 11.4 per cent of total public expenditure and approximately 4.8 per cent of the gross national product.

These simple facts suggest that the training of those who are to hold senior appointments in the management of the service - and the measures necessary for the maintenance of a continuing high standard of performance by those who have already achieved senior rank, is a task of the highest importance.

The Working Party are asked to proceed as follows:

(a) To review current arrangements for the management development, training and selection of senior managers (and potential senior managers) in the National Health Service of England.

For the purpose of the review, the word 'senior' in this context is intended to refer generally to officers holding designated rank in the management of the service at district, area and regional level.

(b) To make such proposals as may seem necessary for the establishment of a satisfactory system having regard to the following considerations:

(i) the need for relationships between the training systems of specialist groups - for example, administrators, doctors, nurses and others concerned with management in the health care system - to ensure a satisfactory preparation for the responsibilities of inter-disciplinary management practice at senior level,

(ii) the need for a continuing and imaginative system of educational support for those already holding senior managerial appointments in the health service,

(iii) the need for flexibility of approach in the determination of a management training strategy to ensure that individuals may have opportunity for ad hoc educational experience - for example, the undertaking of research or attendance at a University postgraduate course,

(iv) the need to recognise that the provision of a system for the care and protection of the health of the population is but one of the public services necessary for the well-being of our society and that therefore the training of those responsible for management in the National Health Service should be planned in such a way as to take this into account.

REVIEW OF SENIOR MANAGEMENT TRAINING IN THE NHS

MEMBERSHIP OF WORKING PARTY

Dr. Bryan Thwaites Chairman	Principal, Westfield College, University of London, and Chairman, Brent & Harrow AHA
Miss W. Frost, OBE	Area Nursing Officer, Bedfordshire AHA
Miss Sheila Garrett	Senior Lecturer, King's Fund College and previously Chief Nursing Officer, St. Thomas' Hospital
Professor Lewis Gunn	Civil Service Professor of Administration, Strathclyde University, and Civil Service College
Professor W. W. Holland	Department of Epidemiology and Social Medicine, St. Thomas' Hospital
Professor Maurice Kogan	Department of Government Studies and Law, School of Social Sciences, Brunel University
Mr. Robert Maxwell	Principal, McKinsey & Company Inc.
Mr. R. M. Nicholls	District Administrator, Southampton & West Hants Health District
Mr. David W. Pace	Area Treasurer, Kensington, Chelsea & Westminster AHA
Mr. E. T. Rees	Area Administrator, Rotherham AHA
Mr. S. Shegog (Secretary)	Deputy Secretary, The Nuffield Provincial Hospitals Trust
Mr. J. S. Tapsfield	Registrar to the Council for Professions Supplementary to Medicine
Professor Michael Warren	Director of Health Services Research Unit, The University of Kent at Canterbury, and Academic Registrar of the Faculty of Community Medicine

EDUCATING THE NHS : ONE PROGRAM'S RESPONSE TO THE TASK - A PERSONAL VIEW

Keith Barnard, M.A.
Lecturer and Deputy Director
Nuffield Centre for Health Services Studies
University of Leeds

This paper will be marked by a noticeable absence of violent language...Whilst this may appear to violate the American tradition of freedom of information, it fortunately will not prevent a highly personalised, iconoclastic and totally objective view of what has happened and may well happen in this field of health studies. The specific brief is to offer an account of how one Centre has been and is responding to the demands, challenges and opportunities during the still on-going period of NHS Reorganisation. The aim of this paper will therefore be as follows: first, to record the essentials of that response; and secondly, to open out the account by considering the background to it, including some UK - US comparisons, current and potential problems, and some possible future foci of concern.

The Background to the Current Situation

Much of the past, and perhaps present, transatlantic dialogue on the development of health administrators seems to this contributor to have been founded on misunderstanding concealed by a common vocabulary, that is, the tendency for the UK to acquire US terminology and put it to a different use. While this is not an occasion for discourse on two nations divided by a common tongue, there are certain observations to be made which are central to an understanding of University involvement in health administration in the UK.

(1) While it was an unsurprising development for US professional schools to develop University programs in hospital administration, the same cannot be said for the UK. In the event, the then Ministry of Health looked at US practice in the early 1950s when it was realised that while a generation of administrators had been acquired in the 1948 take-over, the next generation would have to be trained. But the model public service administrator was (and essentially still is) a liberally educated gentleman (preferably an Oxford graduate) who has learned the skills of his trade through experience and the example of his superiors.

(2) There are, therefore, key differences between the two environments. In the UK, there is no tradition of professional schools in public administration, but there is a major need for education and training facilities for staff of the NHS, which is virtually a massive corporation. The US schools have their students at the start of a largely unspecifiable career and their task is

primarily a one-shot effort at laying comprehensive professional foundations. By contrast, in the NHS, it is possible to conceive a prototype career in the corporation which would offer clear indications for the content and style of a sequence of educational or training experiences. Could and should Universities be involved? This paper will open up this issue for discussion.

But first, what has the NHS made of the situation? The Manchester program established in 1956 drew on and developed US thinking and experience, but was subsequently to suffer immunological rejection. The Nuffield Centre program at Leeds was conceived at much the same time with substantial seed money from the Nuffield Provincial Hospitals Trust and with different objectives: to explore how far University participation could contribute to the mid-career development of hospital administrators who in the main would have had no sustained educational experience since leaving school. The strategy adopted was to offer three or four week intensive residential institutes. Significantly, this experimental program was located in the University's Department of Adult Education and, though paying attention to vocational subjects, had its main roots in the liberal education tradition of British adult education. Its courses do not seem to have been designed for the immediate career advancement of the participants.

Once granted permanent status in 1961, the Centre was to become wrenched from these roots by the change in organisational climate in the 1960s which conceived and nurtured the ideology of management and its attendant doctrines of efficiency and results, only lately embracing a concern for values. The Centre, necessarily adopting a survival strategy given a monopsonic market, responded to the climate and was well placed when the ideology reached its fulfilment in the NHS Reorganisation.

Service to the NHS during the Reorganisation Period

On one very reasonable reading of the situation, the current and future prospects facing this Centre (and quite probably others) have never been better. During the reorganisation period, the Centre embarked on a number of activities which were sought of it by DHSS as parent and protector of the NHS. It was a time when the Centre could enjoy the satisfactions of meeting widely felt needs, not least promoting information exchange among officers performing different administrative functions in various parts of the Service, the analysis of official proposals for organisational change and their implications for providers and consumers of the NHS. This was in a context of great uncertainty and, hence, also of receptivity towards the faculty's personal hypotheses as to what was in everybody's best interest either by way of policy developments, techniques of analysis, or modes of operation. Of course, the actual climate within which it was possible to indulge in this fashion varied according either to the particular uncertainties and forecast developments that were uppermost at a point in time, or to the particular set of personal anxieties of the participant groups.

Thus at different times over the period of 1972-4 which explored, for example, ideas of team work and problem-solving, consensus decision-making, the role of the 'trustee' member, consultation with consumer interests, planning processes and the identification of the 'planner' could bring the Centre staff either considerable satisfaction or great frustration. This period offered the opportunity of discussing the issues of NHS Reorganisation with staff of all disciplines and levels of seniority. The graduate recruit embarking upon his two-year, essentially practical, induction to a career in NHS administration was a familiar client to the Centre staff, as was the middle-ranking mid-career lay (non-medical) or nursing administrator attending a two-month development course. In some ways more interesting, because of the novelty, were the short 2 - 4 weeks) courses aimed, initially at least, at the Chief Officers of all disciplines of the unreformed NHS agencies, around the theme of integration of services through the administrative reconstruction. Later the range of contacts was spread further: first it included the clinicians who were invited to two-day seminars to consider how far Reorganisation would affect them and how, in the new circumstances, they would most effectively play their part in improving the running of the Service; then came a similar opportunity to meet the 'trustee' Members of the new Regional and Area Health Authorities to discuss with them how the new Service would function and be managed and the particular contribution that was expected of them.

But there were also other opportunities presented to Centre staff during this period which offered a promise of interesting future developments. Three may be cited here: (i) the involvement in various ways, including the provision of institutes for their secretaries (executive officers), with consumer Community Health Councils, perhaps the most interesting, if fragile, innovation of of the NHS Reorganisation; (ii) the opportunity to participate in the field trials (dummy run) of the proposed corporate planning system for the reformed NHS; and (iii) acting as consulting advisers to Teams of Chief Officers as they developed for themselves their own modes of consensus management in the spirit of the new era. In all of this activity, both on-campus and in visits to agencies in the field, there was a general feeling, naturally varying in intensity through time, that all the Centres were involved in matters that were real and immediate to the NHS and, because of this, they acquired a new recognition and status as part of the intelligence network, if not the power-structure, of the NHS. Some Chief Officers who had been on particularly successful courses and institutes would keep contact with the Centre afterwards and ask Centre staff for their services locally. Relations with DHSS grew closer as the Department seemingly saw Centres as a source of intelligence on attitudes among NHS personnel and asked them to canvass views on particular proposals under consideration. Lastly, the occasion provided for the significant expansion of faculty and attractive, even exciting, research prospects as the reorganised Service became operational and its behaviour in all its aspects was ripe for observing, analysing and judging.

Service to the NHS since Reorganisation

In the twelve months or so since the new agencies formally assumed responsibility, there has been a distinct change of climate. The steady stream of documents of guidance and instruction from DHSS to field agencies has induced in NHS staff feelings of 'information overload' rather than the earlier starvation which Centres had helped to relieve. And the Socratic promptings of the Centres which had earlier revived a dulled imagination were no longer welcome to harassed officers who were endeavouring very often to bring shape and structure to organisational chaos or, at best, to minimise very imminent disorder. If they were to be given 'academic' help, it had to be prescriptive, addressed to a known problem, easily digested, and making no demands on or for local administrative manpower.

In the eyes of the Service then, if the Centres were to warrant continuing patronage, they had to adjust to the Service's short time horizon. Their help, whether on-campus or on-site, would have to be directed to problems created by the new structure: helping staff adjust to new roles, new tasks, new organisational frameworks. While the idea of general development courses for junior, mid-career and even senior staff has not been abandoned, the new climate of organisational uncertainty, economic difficulty exacerbating resource allocation problems, and increasing industrial relations conflicts, has pointed up the desire by the Service to mount specialist seminars and institutes on specific issues. Industrial relations, management of change, delegation and monitoring of performance, resource allocation and quantitative methods of management would be examples of the issues which have emerged in this way, while DHSS itself has identified corporate planning as being crucial to the successful achievement of Reorganisation objectives.

This new climate has created some demanding new challenges to the Centres: how to make an impact in the increasingly shorter periods of time available to them (general management development courses had been originally conceived as 12-week events, started at 8-weeks in the mid 60s, have in recent years been 6-weeks, and now a request has been made to redesign them so that an officer is never away from the job for more than say 3 weeks at a time by splitting the total period into 2 or 3 modules); how to present material so that it is readily perceived as relevant to officers coming from a wide variety of backgrounds both in terms of their general and professional education and the type of responsibility carried; how to relate the experience on campus to the job situation; how to convince reluctant officers that on various fronts they will be working in an increasingly politicised environment and that their long-held fond belief that 'health should be taken out of politics' very often meant little more than an assertion that everybody should share their particular set of values; how to overcome the near-universal phobia of statistics, finance, and the management sciences.

Pedagogic Style

The Centre's response to these challenges has been largely pragmatic. Since the late 60s, there has been a conscious use of sensitivity training with the particular techniques and emphases changing according to the practitioner employed. Sensitivity training has served two purposes: first, it has, as is always intended, alerted the recipient to the strengths and weaknesses of his personal style and prompted him to contemplate improving it; secondly, and of immediate significance, it has commonly accelerated the evolution of a group identity and a climate of trust, which in the judgment of some course directors has enabled much more learning to take place during subsequent components or modules of a course than might have been the case. Role playing scenario exercises to explore conflict have also been used on occasions, both in respect of conflict in industrial relations and as between agencies and interest groups. In quantitative studies, course participants are eased into data-massage through simple games on the calculating machine. Variations on the project theme are played on both a group and an individual basis: either a local NHS agency kindly consents to be investigated in the hope that there may be a pay-off to them; or the individual frames a project involving work in the job situation which he starts preparing during the first module and presents as a completed piece of work during a follow-up module some weeks or months later.

Teaching/learning techniques have been evolved by faculty both individually and working in cooperation. But it would not be true to say that there has been a collective endeavour to develop a coherent pedagogic style. Rather it has been a matter of riding success when it has been discovered, and individual faculty members have evolved styles and adopted techniques which they feel at ease with and which seem appropriate to the material they are dealing with. What the reader will have discerned or deduced by now is that, given the circumstances in which Center faculty operate, those with a strong sense of 'theater' have consistently been the most effective in making contact with the client body. Yet this may or may not be associated with the quality of their scholarship or the centrality of their message to the problems and issues facing the NHS. The more world-weary practitioners among the faculty not having the theatrical talent might observe that over time technique can be an uncertain aide, as there hasn't been any technique that hasn't been tried and sometimes failed, nor has there been any technique which hasn't been tried and sometimes succeeded.

Given the accuracy of this summary of developments, it will be for others to conclude whether there is evidence of any sophistication of approach. If anything, there is now a tendency emerging among faculty members to draw back from attempting to promote a conscious show of managerial sophistication. Without adopting a contrary posture of academic 'luddism', they are concerned to emphasise traditional virtues of logic, reason, and explicit assumptions, which participants can harness to their

skills of political and inter-personal sensitivity. The contribution faculty can make is to promote a heightened awareness of issues, to offer alternative perspectives, or at the least to help prevent hardening of the mental arteries; this rather than to promote a range of sophisticated techniques, the applicability of which may be limited either by the nature of the assumptions on which they depend, or by the inability of any of the affected parties to understand them.

Client Response and the Magnitude of the Task

In short, the continuing challenge is the attempt to communicate, to make an impact on a heterogeneous clientele, all socialised to the system but having an almost infinite variety of personal and professional aspirations and perceptions. Consider why such a clientele may or may not be responsive. At the extreme, it may be the wrong message at the wrong time in the wrong style for the wrong particular audience. Less dramatically and more frequently, it is the wrong chemistry between course participants or between participants and presenter. Similarly, reasons for a positive response are as many and in antithesis to the diagnosis of a rejection. But the magnitude of the task facing faculty members varies considerably. In the behavioural sphere, where the techniques of experiential learning are well developed, and, when competently applied, make an immediate impact on the innocent participant, the task (though far from negligible) is easier than that of reducing vast areas of economic or statistical theory in a way that makes a greater demand on participants than 'take my word for it'. On the one hand, people are happy to talk about themselves in a controlled situation that lacks the threat and risk such an activity would have in the 'job situation'; on the other hand, they may well feel apprehensive at the sight of curves and equations that resurrect the submerged mental blocks of adolescence. Yet in both cases, faculty know where they are.

Others experience a difficulty of a different order. Unlike the members of an in-company staff college whose position would seem necessarily less ambiguous, the faculty members with the most problematic task are those who become involved in the discussion of government policy, either substantive policies regarding service developments or policies regarding management and organisational arrangements. Are the faculty advocates or analysts of Departmental (DHSS) positions? If analyst, then policies are not presented or defended as their authors intended and, indeed, the analysts may on occasions lead too easily to the rejection of policies. If advocate, then without the detailed background knowledge (especially as to Departmental willingness to concede points or to admit alternative interpretations) the credibility of the presenter is strained as he appears to demónstrate a naivety which could raise questions as to the value of what he has to say. The third possibility of promoting a personal preference or considering a variety of alternative policies, including some not on the public agenda, is at times possible but as often is inappropriate. When the

general form of a Departmental policy is known or anticipated, course participants are seeking to reduce uncertainty and allay anxiety; they are concerned firstly to know the Departmental mind, no matter how profoundly they may wish to disagree with its intent. Logically and theoretically, of course, there is no problem; the problem is in the practice and has its roots in the equivocal position of the education centres in relation to the system. How far in practice can they be independent centers of academic study which their University locus insists that they should be; how far are they expected to fill the role of company staff colleges? (It is interesting to note that university programs are best established in those countries where there is no highly structured medical care system.) While the issue can and does lie dormant from time to time as when there occurs a close identity of interest and perception between sponsors, clients, and centres, the issue is always there. The crucial question which the purist believes will need answering eventually is whether the 'corporation' is willing to sponsor an outside body to act as a paid critic or whether it will use the power of the purse to effectively co-opt that body to perform a basically in-company task. The issues raised here may well be questions surfacing in a different form in the US.

The Problems of Success and Survival

As a program grows in strength and maturity, the problems facing the Program Director grow with it. The skills of grantsmanship become his most precious attribute: as the program expands, reliance on a single source funding becomes more dangerous. How does he develop new markets? What balance should he seek between 'academic' education rooted in degree and diploma courses with their dangers of abstractness and 'trade' training with its dangers of ennervated staff through repetitious teaching? Is there a balance to be struck between research (of whatever kind and focus) and consultancy; between on-campus and on-site activities? How far should faculty be encouraged to maintain or acquire roots in parent disciplines by association with appropriate departments? Is it possible for him to breed 'academic-practitioner hybrids' which the situation appears to demand? In short the Program Director has to minimise the tensions between the values of the host environment, the academic University, and the men of affairs who are his clients and sponsors, the NHS and DHSS.

These are questions very much preoccupying this program as it moves to redress the balance away from training towards research consultancy and academic teaching, including teaching programs at the diploma and masters levels and by developing teaching commitments in other, related fields. In our judgment, this will be to the advantage of the NHS. The inertia of such a large corporation needs to be balanced by some countervailing philosophies: the NHS cannot afford the luxury of incest with the programs.

Prognosis

While the Centre has been searching, sometimes fitfully, for a coherent philosophy and strategy for health service studies, the field has been indulging in an ingenuous belief that 'it is just like industry'. In some measure this conflict continues. The contract commitment with DHSS emphasises management education and while this concept is re-interpreted over time, it may be questioned whether it can capture what seem to some as the key issues which need to be debated and which must occupy the energies of the senior officers of the new authorities: the problem of choice and values, the diplomatic negotiating relations with interest groups and other agencies, the development of new constructive inter-professional relationships among an increasing range of medically and socially related caring disciplines. History does not come in neat packaging. Just as the 19th Century lasted from the American Rebellion to the end of the Great War so, in the NHS, the 1960s stretched from the planned recruitment of graduates to administration in the late 50s to NHS Reorganisation and the eruption of conflict and discontent in the mid-70s. That long decade was the period of solution, if not salvation, by sound management and application of the 'right' techniques. It may be felt that the management philosophy has been found wanting and a change of focus is needed. To secure the necessary reorientation of NHS personnel, it may become necessary to shift the focus of education away from management, even though the magnitude of the management task remains. The role of the Centre might need to revert to the older liberal tradition of adult education, leaving management training to the system itself. Such a metamorphosis is not as yet imminent, but is nevertheless a credible scenario. It is indeed well to remember the Nuffield Centre never became a 'management education centre', but was set up 'for Health Services Studies'. Perhaps it should have been for 'Health Studies'. But at least we kept our options open: and events will surely prove us to have been right.

MANAGEMENT EDUCATION WORKSHOPS

One feature of co-operation between programs involved in management education, research and consultancy for the National Health Service has been a series of joint two-day workshops, held at each education centre in turn and planned in co-operation with the Department of Health.

So far eight of these workshops have been held over the past three years, some of them including membership from programs for the training or re-training of community physicians, and from the education and training officers of the NHS regional health authorities. Amongst areas of common interest studied at these workshops have been the definition of educational objectives for senior management development, participative learning methods, the teaching of quantitative aspects of management, and joint working between education centres and health care facilities.

THE HEALTH SERVICE ADMINISTRATION UNIT
DEPARTMENT OF SOCIAL ADMINISTRATION
UNIVERSITY OF MANCHESTER

Brian Watkin
Senior Tutor

Summary

The Health Service Administration Unit at the University of Manchester is based in the Department of Social Administration, Faculty of Economic and Social Studies, but has strong links with the Manchester Business School - which is also a constituent part of the University - with the Medical School and with the University's Institute of Science and Technology. The Unit is financially supported by the Department of Health and Social Security.

The Department of Social Administration has been educating health service administrators since 1956 when the National Training Scheme for Hospital Administrators came into being as a result of the Guillebaud Report[1] and Manchester was designated as one of the two centres (the other being the King's Fund in London) to provide the theoretical teaching required. In the 1960s the Department was asked by the then Ministry of Health to assist in the provision of short but intensive management courses for experienced hospital and nursing administrators, and in the early 1970s a variety of such courses were provided.

The Department made a major contribution to the preparation of senior medical, nursing, administrative and other health service staff for the total reorganisation of the National Health Service which took place in 1974, and the most recent development has been the mounting of a number of specialised seminars and courses to meet particular training needs identified by the Department of Health and Social Security and other health service authorities.

Research has not figured prominently in the work of the Health Service Administration Unit as such but the Unit's courses have been able to draw on a strong tradition of health service research both in the main Department of Social Administration (associated particularly with the names of Professor T. E. Chester and Gordon Forsyth) in the Institute of Science and Technology (operational research and computer applications in hospital administration, nursing, mental health care, etc.) and in the Medical School (particularly the Departments of Community Medicine, General Practice, and Nursing). However, with changing needs in the NHS and with a changing perception of its own role, the Unit may well find itself more directly involved in research in the future.

The Training of Young Administrators

For the education and training of young administrators, Manchester is linked to two English regions, the North West, based in Manchester, Mersey, based in Liverpool, and to the health authorities of Wales and Northern Ireland. Manchester is thus unique among the English national centres in having to relate to three distinct health service structures and systems of organisation, for health services in Wales and in Northern Ireland differ in quite important respects from those of England.

Originally the National Training Scheme was intended for candidates considered to have the potential for the highest posts in the service, and to benefit therefore from the accelerated experience which the scheme offered. As time went on this view was modified and the scope of the scheme was widened. Less stringent entry requirements were imposed and perhaps as a result the numbers of applicants increased. A trend in recent years has been an increasing proportion of women, in some intakes it has reached 50 per cent. Until 1967 Manchester trainees were awarded a Diploma in Social Administration of the University, but this was dropped since it was felt that Manchester trainees had an advantage not shared by trainees at the other centres. In any case, modifications in the training scheme from that time on meant a reduction in the amount of theoretical training which would have made it impossible for the scheme to meet the requirements of the University for the award of a postgraduate diploma.

Senior Management Training

In January 1969 the Department of Social Administration, at the request of the then National Staff Committee and National Nursing Staff Committee, mounted the first of a series of Hospital Management Courses, eight weeks in duration, for senior hospital administrators and senior nursing administrators from the hospital service. Between 1969 and 1972 the Department provided 11 of these courses. The normal membership was 12 nurses (typically matrons or, as implementation of the Salmon Report gathered momentum, principal nursing officers) and eight administrators (typically hospital secretaries, deputy group secretaries, with a sprinkling of administrative specialists such as supplies officers, management services officers, etc.)

In 1972 the Senior Hospital Management Course was succeeded by the General Management Development Course. The principal change was a reduction from eight to six weeks in duration, but there was also some broadening of the membership to include an increasing number of administrative specialists, engineers, catering managers, pharmacists and heads of paramedical departments. In the autumn of 1974 the GMDC was in turn superseded by the Senior Management Development Course, drawing its membership from all branches of the health service. Typically a course might include second or third in line administrators at area or district, area nurses,

divisional nursing officers, heads of paramedical departments, senior medical officers, and administrative and works specialists.

Finally, in January 1975, the Experienced Senior Manager Course was introduced in addition. This course lasts two weeks and membership includes clinicians as well as medical administrators, together with top ranking nurses, administrators and other health professionals.

Membership lists for the senior courses are drawn up by the DHSS from nominations submitted by the various NHS authorities. The lists are submitted to the university for approval, but informal consultation between DHSS officers and university staff results in the views of the university on course mix and numbers being taken fully into account and also in an understanding on the part of university staff of the problems experienced by the DHSS in providing an ideal mix.

These courses are designed to enable senior officers to consider the relevance to their own work of a wide range of ideas, research findings and techniques which have been found useful in various fields of management, and in particular to direct their attention to aspects of management which are of especial importance at this stage in the development of the NHS. Members are expected to test the theoretical teaching against their own experience and to join in discussion of its relevance and application with university staff and visiting lecturers.

Specialised Seminars and Courses

Manchester's participation in the massive program of retraining at all levels which took place in the months immediately before the reorganisation of the National Health Service on 1 April 1974 has been fully documented in a research report by Professor T. E. Chester.[2] In two years Manchester provided more than 30 courses, ranging from two days to four weeks, for nearly 1,000 participants. The shorter courses were for voluntary members of health authorities, or for clinicians, the longer courses for those thought likely to be appointed to top posts in the new organisation.

Following reorganisation, more specific training needs emerged for particular groups, either as a direct result of reorganisation or because new circumstances threw into greater prominence needs inherited from the past. The introduction of comprehensive health planning and the publication by the DHSS of a guide to the new NHS planning system called for the training of those likely to be responsible for coordinating the contributions of a wide range of professional and other staff, and so Manchester has been providing one-week courses for "key planners" designed to equip them to bring the new system into operation. The setting up of community health councils to represent the consumer in the reorganised health service led to the provision of training

courses for community health council secretaries. In addition specialised seminars have taken place or are envisaged on managing organisational change, employee relations, teamwork skills and other topics.

A number of high-level seminars for members of authorities, chief officers, or senior clinicians - consultants and general practitioners - have taken place. Of particular interest may be the Collaboration Seminars which have brought together chief officers and members of certain Area Health Authorities with their opposite numbers from the local authorities which administer social services, education and other local government activities for the same geographical areas. On each occasion a team of senior civil servants from the DHSS have led discussion, under the chairmanship of Professor T. E. Chester, of various aspects of collaboration and joint planning between the two types of authority. Other seminars have explored problems of the relationship between areas and districts in the reorganised health service, the contribution which clinical members can make to area and district management teams, the management of dental services, and financial resources and management in the reorganised health service.

Finally, a Manchester initiative which has attracted a good deal of attention is a weekend school followed by a series of weekly seminars for young clinicians (registrars and senior registrars) from the teaching hospitals associated with the university. This has enabled the doctors to focus on a number of aspects of management that have a bearing on their clinical work and has been very well received.

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BIRMINGHAM UNIVERSITY'S HEALTH SERVICE MANAGEMENT CENTRE

Derek Williams, Ph.D., Director

The Health Services Management Centre of the University of Birmingham was formed in October 1972 with an initial teaching staff of five. The Centre now has eleven teachers and researchers. This paper begins with a discussion of the circumstances under which the Centre was established, and reviews the ways in which the 1974 reorganisation of the NHS influenced its programs. The salient features of the current teaching program are then examined, and the paper concludes with some speculations about the future of the Centre, its developing relationships with other University departments and the NHS.

Formative Influences

As children are sometimes referred to as 'wartime babies', often to explain some quirk in their physical or mental makeup, so the Health Services Management Centre was and is a 'reorganisation' child. Within a month of its establishment, it began the first of a series of courses to explain the impending major reorganisation of the NHS (planned for April 1974) to groups of very senior personnel from all parts of the service: Medical Officers of Health and nursing officers from local authorities; administrators, nurses and others from the hospital and family practitioner services. The challenge of presenting these courses at such short notice, and helping in other ways to meet the shifting training needs of the reorganisation, has had a powerful influence upon the Centre and the thinking of its staff. Paradoxically, the Centre was also established and its early training programs designed within the framework of some traditional assumptions about what should be taught, when, where, by whom and for whom. Historically, the NHS has tried to meet its management development and training needs primarily through the provision of a hierarchy of relatively short (up to six weeks) multiprofessional courses in management for officers in mid-career: there is no real equivalent to the investment made in the USA, for example, in postgraduate education to Master's Degree level for aspiring administrators. In 1972 these assumptions about the content, membership and purpose of the NHS management development program had not been seriously questioned.

The HSMC was, therefore, in the position of having a radical father, committed to root and branch reform of the health care management system within two years; a conservative mother, respecting the old values and methods, willing to consider change if tested and introduced cautiously and gradually. Mother and father could live together amicably only because they shared one common belief: that the body of knowledge and influence represented by the word 'management' contained the answers to many of the problems of the NHS. Management change, management education and training,

management research and management consultancy could all offer ways of increasing the effectiveness of the service. Accordingly the new unit became the Health Services Management Centre, and its initial teaching staff were selected from disciplines traditionally associated with management matters: an organisation theorist, a social psychologist, specialists in personnel management and operations research, and a planning theorist.

Now, in the aftermath of reorganisation, the position is changing. In parallel with developments in DHSS thinking, the Centre is diversifying its range of activities and the short, heterogeneous membership, general mid-career course is no longer the main medium of action. The original central concern of the Centre with health service management issues is also being re-examined in the light of developing research and teaching relationships between Centre staff, health care practitioners and other University teachers and researchers. It is, for example, proving difficult to develop a health care planning research program, and within this program to identify criteria of planning effectiveness, without reference to the ideas of epidemiologists in the Medical School and to members of the Faculty of Social Sciences interested in wider national, regional and local policy-making and resource allocation issues. From these interactions there seems to be emerging a view of the Centre's future field of interest which marks a significant departure from the original position. Some of these developments will now be examined in more detail.

The Impact of Reorganisation

The work of the Centre, and its relationship with neighbouring NHS authorities and the DHSS, has been fundamentally influenced by the process and consequences of reorganisation. Not all the implications of reorganisation are yet clear, but a pattern is beginning to emerge. First and most obviously, the Centre was influenced by its encounters with so many of the senior officers of the service through the general reorganisation training program. Then, as reorganisation approached and passed, and each phase of reorganisation revealed its special problems, the Centre was encouraged to contribute to the solution of these problems: helping clinicians to understand how reorganisation might affect them; briefing the membership of the new authorities; developing an understanding of the new planning system, and so on. These experiences greatly increased the Centre's knowledge of the idiosyncracies of the service and began to highlight the interdependence between health care management and the wider issues mentioned earlier.

A more fundamental consequence of reorganisation is currently becoming apparent. The new management arrangements call for greater decentralisation of decision making from the DHSS to regional and area health authorities, and the makers of education and training policy in the DHSS cannot - nor do they

wish to - escape this commitment to decentralise. Indeed, the DHSS is currently urging areas and districts to accept local responsibility for management development. So now it looks as if the earlier and relatively simple program-commissioning relationship between the Centres and the DHSS will be replaced by a more complex network of links between the Centres, the DHSS and the health authorities in the field. Such a relationship will certainly not be problem free, given the current uncertainties and anxieties about the appropriate policy-making responsibilities of each main tier in the hierarchy, but may eventually provide the service with more flexible management development, education and training strategies. The HSMC program for the coming academic year, developed in collaboration with the DHSS, reflects the beginnings of this shift in emphasis.

The Current Program

In the coming year the HSMC will provide only one of the traditional 6-week general multidisciplinary management courses for senior officers in mid-career. In the past the Centre has tried to relate these courses as closely as possible to the situations, tasks and problems of those attending: commonly, their focus has been upon health service management systems, roles and relationships, policy and planning issues, quantitative analysis and personnel management. But, with a membership drawn from several professions and all parts of England, significant current or future role relevance has sometimes been difficult to achieve for all participants and there is inevitably a Procrustean flavour to some parts of the program. Research projects, both local and national, are currently attempting to evaluate and increase the effectiveness of the total senior management development course programs, but the early results are inconclusive. We are contributing to this research in two main ways:

i) through experimentation within the parameters set by the national senior management development course program, e.g., variations in length, content, teaching methods and membership.

ii) through a more fundamental study of the nature of health service management roles, relationships and processes aimed at identifying long term management education and training needs. This study is currently drawing us into a special relationship with a number of neighbouring health authorities, and in the coming year we intend to cooperate with the senior officers of these authorities in a series of on-site need-identification and training activities. At the end of these exercises we hope to be able to compare the benefits and disadvantages of investing similar resources in this kind of work, at the borders of OD, action research and consultancy, rather than in the more normal and formal University-based senior management development course.

In the past, one of the consequences of investing heavily in general management training and development has been a failure to meet a number of very important specialist training needs. Reorganisation has revealed some of these needs, for example, the requirement to communicate an understanding of planning concepts, strategies, methodologies and techniques to those community physicians and administrators charged with introducing new health care planning systems. Other specialist needs relate to some major problems of contemporary British society, for example, the need to help NHS personnel officers and others cope with industrial relations problems. The Centre will provide a wide range of seminars and courses in these and similar areas in the coming year. Some of these will be commissioned and financed nationally; others will be developed in consultation with the personnel and training officers of nearby regional and area health authorities. (Often these specialist activities will relate to the research interests of Centre staff and contribute to the further development of these interests.)

The Centre is, therefore, involved in a range of post experience training activities: some traditional, some experimental, some nationally financed, some developed through regional and local arrangements. We are also extending our postgraduate activities. We provide tutorial support and a series of linked induction and follow-up courses for newly appointed graduate national trainee administrators. A potentially very important development in a related area is that the Centre, through its links with the Medical School, teaches the management module on a two-year inter-university postgraduate scheme to prepare community physicians for the examinations of the newly created Faculty of Community Medicine. To a considerable extent, the future management effectiveness of the NHS depends upon the development of a harmonious working relationship between administrators and community physicians on and around the new multidisciplinary consensus-forming management teams.* In contrast with what may be seen as the more specific responsibilities of the other members of these teams, administrators and community physicians share general 'enabling', coordinating responsibilities. But neither profession has a thorough understanding of the role of the other, and there is potentiality for conflict in many areas, for example, over the introduction and coordination of planning and information systems, and the servicing of clinician representative subsystems. The Centre can, by integrating the two programs where possible, contribute to the development of a common understanding of and approach to these and related management problems.

Overseas readers familiar with the British scene may be surprised to read that we also cooperate with another University department - the Institute of Local Government Studies (see below) - in providing a Master's Degree (M.Soc.Sc.) specialising

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* For a general presentation of the new management systems and processes see Management Arrangements for the Reorganised NHS, HMSO 1972.

in Policy Making and Management in either Local Government or the National Health Service. Through a DHSS financed scheme to develop future health service management educators and trainers, a small number of NHS staff are able to join the staff of the Centre whilst reading part time for the M.Soc.Sc. over a two-year period. (Those appointed spend approximately half their time on this course of studies: the rest of their time contributing to the research, teaching and advisory work of the Centre.) Since the establishment of this scheme in 1973, a number of full time students have also taken the degree, including some from overseas. The present basic structure of the degree is as follows:

1. Compulsory courses:

   The Study of Public Policymaking in Local Government and the National Health Service

   Organisation Theory in Local Government and the National Health Service

2. Optional courses (select one):

   Decision Simulation

   Environment of Health and Local Government

   Local Government Finance

   Personnel Management in Local Government and the National Health Service

   Other Courses offered in the Faculty of Social Sciences

3. Dissertation

The Centre's Graduate Admissions Tutor would be glad to supply further details of the scheme.

The Future: Some Open Issues

No one knows how British health service management education will develop, nor what part the Universities will play in the future. One of the most important current issues is whether or not the DHSS will modify its traditionally cautious attitude towards supporting the 'long course' or postgraduate program, linked perhaps to a higher degree, as a regular means of educating the most senior officers of the future. In some quarters it is strongly believed that it should. Some would argue that the response of many administrators to the trials and strains of reorganisation would have been less nervous and eclectic had they been equipped with 'conceptual frameworks' to help them understand, anticipate and manage what was happening around them. Some interest groups are arguing, perhaps a little artlessly, that the Business Schools should be asked to provide Master's Degree programs for NHS Administrators and others. But what conceptual frameworks do NHS officers need, and could the Business Schools provide them?

One could begin by listing the academic disciplines that should be represented in any major postgraduate program: social, economic, financial, analytical, policy sciences. Business Schools could provide these. They could also nod in the direction of the 'community' element in many health service issues by introducing some ideas that do not normally play a major part in Business School postgraduate programs: a little urban sociology, a little more political science. But how these disciplines are presented and related to each other depends upon how intimately the teachers understand some peculiarities of the health care system and its environment. Is the complex relationship between institution and the community understood? The interweaving of quantitative analysis and value judgments? The role of the professional? From their basically strong disciplinary starting points the Business Schools could pick up the necessary insights, if the staff concerned were motivated enough and informed by epidemiologists and others. But it would take time.

We are hoping to approach the problem from another direction, by beginning with sensitivity to the environment and building up our strength in what are then seen to be relevant disciplines. The Centre itself is, of course, far too small to set out along on such an ambitious path. But within the University we are associated with a number of departments with similar interests: an Institute of Local Government Studies, a Social Services Centre, a Centre for Urban and Regional Studies. We are proposing to bring these units together into a 'School of Public Policy' which would have a research and teaching staff of nearly a hundred, sharing an interest in identifying and helping to solve the problem of community service management. The potential of such a school for staff development, generating ideas and exercising influence in the field, would be considerable. Apart from these intrinsic major academic benefits, the creation of such a large academic community might yield a number of important side-benefits. We would, for example, expect to attract into the school for short semi-sabbatical periods senior officers from health, local government and other authorities, who would pursue particular specialist interests in tutorial partnership with staff with similar interests.

There would, of course, be problems. What would be the links with the Medical School? How much planning and resource allocation freedom could be left with each unit within the School? These problems are currently being studied. At present we feel that we have enough in common with our sister Centres to make the attempt worthwhile. The ultimate aim, which we are a long way from achieving, is to create a teaching, research and consultancy group which not only influences policy and practice in the field but also fulfills the historic University function of forming and disseminating ideas.

TRAINING IN HOSPITAL ADMINISTRATION AT THE KING'S FUND COLLEGE, LONDON

Frank Reeves, Director

King Edward's Hospital Fund for London is a charity just over seventy-five years old and created especially to benefit the hospitals in London. The King's Fund pioneered management training in the NHS by the creation of four colleges between 1949-1953. Two of these were for nurses, one for administrators and one for caterers. In 1968 the four colleges were merged into one institution, now called the King's Fund College.

Before the 1939/45 war there were isolated schemes of training in hospital administration, usually in the form of an apprenticeship and based on individual hospitals. The major exception was the London County Council which for the hospitals under its control had a recognised recruiting and training scheme. This was however an "on the job" training scheme with little theoretical instruction. Immediately after the war the King's Fund was turning its thoughts to the need for training in administration and, as a result of a suggestion by one of the then largest voluntary hospitals, The London, gave a lead by inaugurating a scheme to provide bursaries in hospital administration for men whose careers had been interrupted by the war. In cooperation with some of the larger hospitals it was decided to offer twelve bursaries to the value of 600 pounds per annum each.

In June 1947, a further eight bursaries were offered. These were followed by others, some awarded to men already in the hospital service, but as early as 1948 and before the actual introduction of the National Health Service, although the Act was passed in 1946, the question of whether the Fund could make some useful contribution by providing further facilities for the study of hospital administration was receiving urgent attention. The King's Fund was therefore in the forefront in recognising that the National Health Service demanded trained administrators to preserve, under the new conditions, the best elements from the old traditions.

So, in December 1949, speaking at the General Council of the Fund, held in St. James's Palace, London, His Royal Highness, the late Duke of Gloucester, who was then President of the Fund, said "The most important new departure is the establishment of a Staff College for Hospital Administrators. Today, as a result of the new Act merging two separate administrative traditions and adding something of its own, there is evidence of a widespread need for practical help; and many believe that hospital administration, as understood in this country, is at the crossroads. Nobody, the Minister least of all, wants a bureaucratic hospital service; and if that is to be avoided, an active policy must be pursued aiming at flexibility and initiative. We believe that the foundation of a residential staff college where the different interests can come together may prove a decisive event. We want the hospital adminis-

trators of tomorrow not only to be efficient but to work out for themselves how to let the humanity which is the essence of the hospital shine through and illumine the administrative detail. We are therefore taking counsel with others interested, and notably with the Institute of Hospital Administrators, as to how best to achieve this result."

The college, the first of its kind in the United Kingdom, was founded to provide:

(i) Refresher courses for those already holding posts in the hospital service

(ii) Longer courses for a limited number of younger men drawn, as far as possible, from within the service

(iii) A continuous study of the problems and practice of hospital administration, with publication of the results from time to time

(iv) A common meeting ground for all those engaged in the service

In pursuance of its aims, the college soon started longer courses for a limited number of young men from the hospital service, these courses varying from three-months to two-years. There is no doubt that these courses were the inspiration which led to the Ministry of Health, as it then was, launching in 1956 its first official training course for potential hospital administrators.

As one might expect from a Government department, they were cautious at first. The initial annual intake was 16, eight went to the University of Manchester under Professor T. E. Chester in the Department of Social Administration, and eight to the Staff College in London under the King's Fund. At Manchester the training was linked with the Diploma Course in Social Administration lasting an academic year. Practical attachments were also provided on a pattern similar to the American scene of that period.

At the Staff College in London, the training was a 'sandwich' course of attachments to hospitals, Regional Boards and a short industrial spell together with periods of theoretical instruction in College. The defined purpose was to train hospital administrators who with others in the service should be capable in due course of holding most senior positions. This early recruitment was mainly of graduates in virtually any subject, together with in-service officers with a professional qualification at least at intermediate level.

In 1962 the annual intake was stepped up from 16 to 46 and the Nuffield Centre for Hospital and Health Services Studies at the University of Leeds came into the picture, receiving ten

trainees initially with eighteen each going to London and Manchester. At the same time the length of training was reduced to two-and-a-half years.

The hospital service almost from its inception was the focus of various reports by committees established by the Ministry of Health. For example, the Bradbeer report in 1954 on the internal administration of hospitals, stressed that the administrative pattern must remain flexible and that there must be a concept of partnership between medical, nursing and lay administration. The Guillebaud report in 1956 was set up to enquire into the cost of a national health service and was really the launching pad for national training in administration. This was followed in 1957 by the Noel Hall report which recommended the development of training schemes, and finally, by the Lycett Green report in 1963 with recommendations on recruitment, training and promotion of administrative and clerical staff. This report was accepted in full by the Ministry of Health. The National Staff Committee it had recommended was established, and training given was revised, being reduced to two years in duration. The annual intake was reduced by one to 45, so that fifteen students could be attached to each of the three training institutions, the two universities at Manchester and Leeds and the Staff College in London. Recently, a fourth centre was added, so that the sixty entrants now recruited each year are divided over four teaching centres:

Department of Social Administration
University of Manchester

Nuffield Centre for Health Service Studies
University of Leeds

Department of Health Services Management
University of Birmingham

King's Fund College, London

In 1975/76 the basic course will be further reduced to what in effect is fifteen months, after which trainees will at some time return for an eight-week junior management course. Arrangements for the selection of these trainees is made by the Department of Health but interviewing panels include serving administrators, representatives from teaching centres and from regional personnel departments. Initially, some 1200 applications are now received annually, but after interviews organised regionally, some 150/200 are interviewed in London for the final sixty places.

With the advent of the National Staff Committee there was a change in methods of training, for it was quickly realised that training was a continuous process and not something which happened just at the commencement of a person's professional career. Accordingly, a management development policy was established in which it was decreed that training should be at three levels: the initial training; at middle management, and senior management levels.

In 1962 the King's Fund staff college launched its first advanced management course. This was designed for officers already occupying senior posts in the hospitals. It was followed by more of these courses in 1963, each lasting four-weeks, and then followed by one or two of eight-weeks duration multidisciplinary in membership. It was no surprise therefore at the college when the management development policy of the National Staff Committee recommended middle management courses of four-weeks duration and senior management courses lasting eight-weeks.

Membership of the general management courses covers a number of disciplines including medical, nursing, administration, professions supplementary to medicine, catering, engineering, ambulance officers. Selection for these courses is usually by nominations from employing authorities to the DHSS, where selection is made in consultation with the college. Originally of eight-weeks' duration, these courses were reduced to six-weeks in 1973. In 1975/76 there will be a further reduction to four-weeks with the possibility of an additional week if the reduction in length proves too drastic.

In the late 1950s, the King's Fund staff college had run a number of courses in management, again lasting four-weeks, designed especially for physician-superintendents of psychiatric hospitals. In 1963, the Chief Medical Officer of the Ministry of Health, in as historic a setting as the Terrace of the House of Lords, said to the Principal of the college "why don't you do more for the doctors?" As a result of this conversation, one-week courses were mounted in management appreciation for clinicians, mixed as to geographical location, hospital background and individual specialty. These courses were initially received with some caution but gradually it was realised that this was no dastardly attempt by the administrators to convert the physicians, but rather an endeavour to show the clinicians that they were involved in management of the hospitals whether they realised it or not and whether they liked it or not!

In summary, courses in the college now fall into one of five categories:

a) training in management for the graduate entry each year to the National Training Scheme. This is a 'sandwich' course commencing in September each year and lasting in all for 18/24 months although the actual time spent in the college per course is now reduced to 18 weeks;

b) general management courses for potential senior managers;

c) specific courses directed at areas of management where senior officers need additional experience and training, for example, industrial relations, planning, management information, financial administration;

d) management appreciation courses for members of the medical profession in hospitals and general practice;

e) numerous seminars and courses often of an international character.

It will be seen that most of the courses in the college have as their ultimate objective the improvement of skills for senior management. The college firmly believes in participative methods of teaching; 'straight' lectures therefore rarely occupy more than 20% of the time. Project exercises undertaken in small groups are a feature of all courses and educational aids such as films and film strips are widely used. The college staff has of course changed over the years; the philosophy has remained constant.

The objective of all college activities is an endeavour to improve management efficiency in the NHS. Possibly the principle most firmly held by the staff is that officers, particularly senior officers, who must work together in managerial situations should also be trained together.

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